MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

# PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE: 113

2. RECIPIENT'S MEDICAL ASSISTANCE I.D. NUMBER: 1234567890

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima

4. RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 53725

5. DATE OF BIRTH: MM/DD/YY

6. SEX: M ☐ F ☒

7. BILLING PROVIDER TELEPHONE NO.: ( XXX ) XXX-XXXX

8. BILLING PROVIDE NAME, ADDRESS, ZIP CODE:
I. M. Provider
1 W. Williams
Anytown, WI 53725

9. BILING PROVIDER NO.: 12345678

10. DX: PRIMARY: 436 - Cerebral Palsy

11. DX: SECONDARY: 389.9 - Hearing Loss

12. START DATE OF SOI: N/A

13. FIRST DATE RX.: N/A

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| 92507 | | 8 | 1 | Speech Therapy, Individual | 52 | XX.XX |
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| | | | | | TOTAL CHARGE | 21 XX.XX |

An approved authorization does not guarantee payment. Reimbusement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

22. MM/DD/YY — DATE

23. I. M. Provider — REQUESTING PROVIDER SIGNATURE

**(DO NOT WRITE IN THIS SPACE)**

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____ PRODEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE _____ CONSULTANT/ANALYST SIGNATURE _____